

April 1, 1998

## **NATIONAL HOME AND COMMUNITY-BASED CARE STRATEGY**

1. **PURPOSE:** This Veterans Health Administration (VHA) Directive articulates national VHA policy and establishes a national VHA strategy that will provide the context for expanding and developing home and community-based care within each Veterans Integrated Service Network (VISN) to respond to the healthcare needs of enrolled veterans.

### **2. BACKGROUND**

a. Home and community-based care is a vital component of an integrated healthcare delivery system. Both the healthcare industry, in general, and VHA, in particular, are placing greater emphasis on outpatient and community-based care rather than traditional inpatient care. Between 1988 and 1996 Medicare spending on home care grew from \$2 to \$18 billion, and the number of home healthcare agencies increased from 5800 to 9000. A recent American Medical Association survey reported that for every patient in a nursing home, there are three more severely impaired patients cared for in their own homes. An estimated 20 percent of patients over age 65 have functional impairments with related home care needs, and 44 percent of all patients discharged from the hospital by primary care physicians require post-hospital medical or nursing care that cannot be provided in the home by family or friends alone.

b. In 1996, 173,000 veterans needed non-institutional home and community-based care on any given day. The Department of Veterans Affairs (VA) estimates that number will increase to 180,000 by 2005. Of the 173,000 veterans needing this level of care last year, 75,000 were Category "A" veterans. In 1996, VA met the home and community-based care needs of 8,300 Category "A" veterans daily, or 11 percent of those in need of care. The aging and disabled veteran population, with its prevalence of complex chronic illness, is creating a new balance between acute care needs and chronic, long-term healthcare care needs. New eligibility rules make it possible and necessary for VA to respond to the increasing demand for home and community-based services. The shift from episodic treatment of illness to managing the healthcare needs of an enrolled population of veterans will require innovative approaches to care. Home and community-based services must be integrated with primary, secondary and tertiary care in such a way that reliable, comprehensive healthcare is provided to veterans in an individualized, seamless, coordinated manner across settings and among providers.

c. The VHA can build on its unique experience and expertise in providing interdisciplinary, long-term home-based care to seriously chronically ill veterans as it expands home and community-based care. VA Home-Based Primary Care (HBPC) can provide a strong base for developing and coordinating an array of services for both long-term chronically ill veterans and those needing short term home care services. The VA can provide national leadership in this critical area of healthcare by developing an innovative, flexible approach to home and community-based care that is fully integrated into the healthcare system and uses resources efficiently and effectively to meet the needs of an aging and chronically ill population.

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### **3. POLICY**

a. **Objectives.** The specific objectives of this policy are to:

(1) Provide the most appropriate care to veterans in the most appropriate setting to achieve optimal health outcomes and quality of life.

(2) Assure that a comprehensive array of high quality healthcare services are available in the community to facilitate early discharge from acute care settings, prevent avoidable hospitalizations and reduce unscheduled emergency care visits.

(3) Provide services that improve and maintain functional capacity so that the veteran may continue community-based living.

(4) Ensure that access to care is appropriate and timely.

(5) Provide for continuity of care over time and across settings by appropriately integrating an array of home and community-based services into the coordinated continuum of care provided by each VISN.

(6) Promote innovation in developing new models and approaches to home and community-based care, incorporating evaluation and research as integral components of program change.

(7) Assure accessibility, reliability and quality of all services, whether provided directly by VA or through arrangements with community providers.

(8) Provide compassionate, humane care that includes the patient and family in making informed decisions regarding the use of home and community-based services.

b. **Policy Elements.** This policy addresses:

(1) The array of services included in a comprehensive home and community-based care strategy.

(2) Programs that deliver these services, including VA programs, non-VA programs, and new models of care.

(3) Organizational structures and processes necessary for providing coordinated, integrated and efficient home and community-based care.

(4) The strategic planning process.

c. **Array of Services.** The flexible use of an array of coordinated services is necessary to assure that veterans receive the most appropriate care in the most appropriate setting to achieve

optimal health outcomes and quality of life. A comprehensive home and community-based care strategy should include access to the following services:

- (1) In-home care, including all of the following services:
  - (a) Short-term, post-acute, and rehabilitation services.
  - (b) Long-term chronic care.
  - (c) Palliative and end-of-life care.
  - (d) High-tech care, including infusion therapy.
  - (e) Respiratory therapy and ventilator maintenance.
  - (f) Mental health and psychiatric care.
  - (g) Personal care and homemaker services.
  - (h) Prosthetic services.
- (2) Respite care services.
- (3) Adult day healthcare services.
- (4) Other community-based services (e.g., transportation, home delivered meals, telephone support, senior center programs, friendly visitors, assisted living, etc.).

d. **Programs That Deliver These Services.** Services may be delivered directly by VA or through arrangements with non-VA community providers. The coordination and integration of a “package” of locally available services is often essential to assure timely, equitable access to the array of services necessary to successfully manage the care of veterans in the community. The following list of programs reflects both existing programs and new models that are being developed; it is not intended to be an all-inclusive list of mandated programs (see App. A for definitions).

(1) **In-home Programs**

- (a) VA Home-Based Primary Care (HBPC);
- (b) VA Spinal Cord Injury (SCI) HBPC;
- (c) Medicare-Certified Home Health Agencies;
- (e) Fee-Basis Home Care;

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- (f) Hospice (VA Hospice, Medicare-Certified Hospice, Community Volunteer Hospice);
- (g) VA Homemaker/Home Health Aid Program (H/HHa); and
- (h) Other community programs (e.g., those provided through Department of Rehabilitation Services, County Health Departments, Area Agencies on Aging, Department of Health and Human Services).

### **(2) Respite Care**

- (a) VA Respite Program,
- (b) Hospice Respite Care, and
- (c) Community Respite Care Programs.

### **(3) Adult Day Healthcare**

- (a) VA Adult Day Healthcare Programs,
- (b) Contracted Adult Day Healthcare, and
- (c) State Veterans Home Adult Day Healthcare.

### **(4) Innovative Models, Demonstrations and Pilots**

- (a) Program of All-inclusive Care for the Elderly (PACE).
- (b) MediCaring.
- (c) In-home respite.
- (d) Disease management models.
- (e) Enriched housing, assisted living, and community residential care.
- (f) Social health maintenance organizations.
- (g) Disability management models.
- (h) Prevention of secondary complication models.
- (i) Specialty primary care models.
- (j) Rural disabilities projects (Montana and Arkansas).

(k) Telemedicine initiatives.

(l) VA initiated innovations and demonstrations such as: Care and Assistance for Rural Elders (CARE) in VISN 7, and Patient Access to Community Health (PATCH) in VISN 15, Teleheart CHF Management Program in VISN 8, and Vets Helping Vets in VISN 8.

e. **Organizational Structures and Processes.** In order to provide reliability and continuity of care for eligible veterans over time and across settings, a sound infrastructure is essential. Organizational structures and processes must be put in place that promote the philosophy and practice of individualized, comprehensive, integrated home and community-based care. Necessary organizational processes include the following:

**(1) Assessment and Referral**

(a) A coordinated referral process based on standardized assessment of patient needs, including functional status;

(b) A coordinated referral process that is linked to discharge planning and continuity of care planning;

(c) Defined criteria for access to available services and programs; and

(d) A process that assures timeliness of referrals.

**(2) Care Coordination**

(a) Care management within the context of primary care teams and specialty care teams that also deliver primary care.

(b) Care management and/or coordination across settings and programs.

(c) Twenty-four hour, 7-day-a-week access to services and coordination of care.

(d) Patient and family participation in healthcare decisions.

(e) Streamlined care management that avoids duplication of care management functions.

**(3) Evaluation and Accountability**

(a) A process for determining the responsible provider and defining accountability when the patient is receiving services from more than one provider or program.

(b) Ongoing monitoring of functional status, quality of life, and other patient outcomes using standardized measures.

(c) Ongoing monitoring of customer satisfaction using standardized measures.

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- (d) Standards for and/or evaluation of services provided by non-VA providers.
- (e) System-wide, state-of-the-art home care outcome measures.
- (f) Performance standards (e.g., same-day service for durable medical equipment).
- (g) Ongoing, real-time measures for continuous quality improvement of programs and services.
- (h) Comparison of VA care with that provided by non-VA programs in the community.

### (4) **Research**

- (a) Support for demonstration projects for new and innovative projects and strategies, including an evaluation component;
- (b) Identification of best practices, through literature reviews, case examples, existing data, primary data collection; and
- (c) Identification of state-of-the art assessment and outcome measurement tools

### (5) **Information Systems**

- (a) Identification of which patients receive which services;
- (b) Monitoring utilization of services across the entire continuum of care;
- (c) Providing process and structure information (e.g. staff mix, patient acuity, components of service provision);
- (d) Monitoring outcomes;
- (e) Providing cost data; and
- (f) Providing access to patient care data across sites of care.

f. **Strategic Planning Process.** System-wide strategic planning for home and community-based care is essential at all levels. The strategic planning process should include:

- (1) Identifying the strengths and weaknesses of existing programs relative to needs of the veteran population through a population-based planning model.
- (2) Identifying the need for program expansion, development of new programs, modification of existing programs, and the potential for piloting innovative models.

(3) Identifying the strengths and weaknesses of relationships with community providers and developing a strategy for partnerships, sharing, and coordination of services with non-VA providers.

(4) Considering local and regional home care service contracts and purchase agreements.

(5) Achieving more efficient utilization of resources (e.g., through flexible scheduling, using state-of-the-art technology, telemedicine applications, adequate clerical support and communications equipment).

(6) Including representatives of VA home and community-based care programs, as well as experts from other areas and external stake-holders, in the strategic planning process (e.g., developing network based home and community-based care work and advisory groups).

(7) Fully integrating home and community-based services with inpatient, outpatient and ambulatory care programs and services within the context of primary care.

(8) Promoting access to and coordination with ancillary services such as laboratory, radiology, pharmacy and durable medical equipment.

(9) Collecting cost and utilization data across settings to begin to be able to compare aggregate costs for patients receiving different kinds of care and services.

#### **4. ACTION**

a. VISNs will develop, implement and regularly review strategic and tactical plans for expanding home and community-based services, including the allocation of adequate personnel, equipment and other resources.

b. The Geriatrics and Extended Care Strategic Healthcare Group will provide guidance, consultation and dissemination of information.

c. The Geriatrics and Extended Care Strategic Healthcare Group will support VISN and local leadership in all aspects of improving the provision of home and community-based care.

d. Health Services Research and Development, through the Chief Research and Development Officer, will support the evaluation of outcomes and cost-effectiveness of new models of providing home and community-based care.

f. The Office of the Chief Information Officer (19) will ensure that national data systems support home and community-based services.

#### **5. REFERENCES:** None.

**6. FOLLOW-UP RESPONSIBILITY:** The Office of Extended care (114) is responsible for the contents of this Directive.

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**7. RESCISSION:** This VHA Directive expires on April 1, 2003.

S/ Robyn Nishimi, Ph.D. for  
Kenneth W. Kizer, M.D.. M.P.H.  
Under Secretary for Health

Attachment

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## ATTACHMENT A

**DEFINITIONS**

1. **Home-Based Primary Care (HBPC).** A designated HBPC is a program providing primary healthcare, delivered by an interdisciplinary team of VA staff, to functionally dependent, homebound patients. Services include medical care, nursing care and education, rehabilitation, nutritional counseling, and social work.

a. HBPC manages: long-term care patients with multiple, complex medical problems requiring prolonged intervention to maintain status and retard decline; terminally ill patients, and as resources permit, certain patients with relatively short-term problems who need skilled, high-tech health services, home training or home adaptation.

b. Medications, supplies, medical equipment, and assistance with home improvements and structural alterations are provided. Caregiver support and training are provided. Bereavement care is offered to survivors of deceased patients for up to 6 months. At affiliated medical centers, HBPC provides comprehensive training in primary care of long-term patients to medical residents, geriatric fellows and allied health professionals.

2. **Medicare-certified Home Health Agencies.** Medicare pays for intermittent skilled nursing care, home health aide services, physical therapy, occupational therapy, speech therapy, medical social work services and durable medical equipment (with a 20 percent co-payment). Services must be provided by a Medicare-certified agency. To qualify for home care under Medicare, a patient must have at least one skilled need. Without the continuing presence of a skilled need, supportive services such as home health aide visits cease. Most Medicare home care is for relatively short-term post-acute care. However, some chronically ill recipients can receive care for long periods, i.e., those with indwelling catheters, blind diabetics, psychiatric patients requiring intramuscular medications.

3. **Fee Basis Home Care.** The Veterans Health Administration (VHA) authorizes payment for medically necessary, skilled home care services for eligible beneficiaries on a fee for service basis. Nursing, physical therapy, occupational therapy, speech therapy, and social work are examples of allowable services. Fee Basis, except for patients in need of bowel and bladder care, does not pay for home health aide visits. The Department of Veterans Affairs (VA) Clinic of Jurisdiction pays a per visit rate to the community home health agency providing care. It is possible to establish a preferred provider or negotiated rate with a community agency. The total cost of Fee Basis care for any patient cannot exceed the cost that would have been incurred if the veteran were treated in a contract nursing home during one month.

4. **Homemaker/ Home Health Aide (H/HHA) Program.** The program provides homemaker/home health aide visits to eligible beneficiaries using Contract Nursing Home funds. Expenditures for a veteran may not exceed 65 percent of the average nursing home per diem rate. Veterans enrolled in this program must be in receipt of primary healthcare from VA and will meet program criteria including the need for nursing home care.

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**5. Hospice.** Medicare, many state Medicaid programs, and some private insurance plans offer a hospice benefit to their beneficiaries. Beneficiaries waive curative treatment options in favor of palliative services: comfort care, counseling, and supportive home care visits for terminally ill individuals and their families. The patient's physician certifies an expected life expectancy of less than 6 months. Hospice provides skilled nursing, home health aide, social work, and chaplain visits. Medications for the terminal condition, durable medical equipment, and supplies are furnished. Bereavement counseling is provided to survivors of deceased patients.

**6. Adult Day Healthcare Program (ADHC).** ADHC is a therapeutically oriented outpatient day program that provides health maintenance and rehabilitative services to frail elderly persons in a congregate setting. ADHC is provided in a protective setting during part of a day but less than 24-hour care. Individualized programs of care are delivered by health professionals and support staff, with an emphasis on helping participants and their caregivers to develop the knowledge and skills necessary to manage care requirements in the home. Its predominant focus is a therapeutic one, directed at persons with disabling conditions and medical disorders, thus distinguishing ADHC from social day care.

**7. Respite Care.** Respite care is a program which provides veterans with hospital or nursing home care on a short-term basis to give the caregiver a period of relief or respite from the physical and emotional burdens associated with furnishing daily care to chronically ill and disabled persons. Respite care is planned in advance for the benefit of the caregiver rather than being incidental to the provision of necessary medical care of the patient. Respite care enables the caregiver to continue in the caregiving capacity and permits the veteran to continue to live at home.

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